Smile Dental

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	
Do you use controlled substances?	○ Yes ○ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain In Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
			Yellow Jaundice ○ Yes ○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____ Date: _____

Smile dental

Dr. Troy Hutinger
110 W Sneed St. Centralia, Mo. 65240
573-682-5616 (phone) 573-682-5626 (fax)

Patient Records Access Form

Patient's Name (Print): _____Patient's DOB: _____

I would like to obtain a copy of my protected health information records at this practice.

I would like to obtain:

() My complete record at this practice

() My record for the time period _____ to _____

() A specific section of my record (please describe): _____

_____

_____

_____

() I would like to pick up the copy of my records on _____

() Please mail the copy of my records to_____

() Please email the copy of my records to_____

_____ _____

Signature of Patient/Guardian Date

_____

Please Print Name

Smile dental Centralia

Troy Hutinger, DDS

110 W. Sneed St. Centralia, MO

573-682-5616

Patient's Name (*Print*): _____ **Patient's DOB:** _____

Consent for X-rays and Photographs

I understand that radiographs and photographs will be necessary in order to properly diagnose any dental disease, such as decay and gum problems. Dental photography may also be used for treatment planning and recording of pre-treatment and post-treatment results. I hereby give permission to Dr. Hutinger or a member of his team to take necessary radiographs and photographs. I understand that these records will become part of my personal dental file and may be used for communicating with laboratories, insurance companies, or as teaching aids.

The Financial Policy

General – Thank you for choosing our practice as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read, and sign prior to treatment. All patients must complete our New Patient Medical History Form, HIPAA, and Consent for X-rays and Photographs forms before seeing the Doctor. **WE ACCEPT CASH, CHECK, VISA, MASTERCARD, DISCOVER, AND CARE CREDIT.**

Regarding Insurance – Fees are estimates only, are valid for one year from the date shown, and are subject to revision. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment.

Regarding Insurance Plans Where We Are A Participating Provider – ALL ESTIMATED portion and deductibles are due prior to treatment. In the event that YOUR insurance coverage changes to a plan where we are non-participating providers, refer to above paragraph.

Usual and Customary Rates – Our practice is committed in providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients – Adult patients are responsible for full payment at time of service.

Minor Patients – The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to be approved: Visa/Mastercard/Discover/Care Credit, or a payment by cash or check at time of service has been verified.

Missed Appointment – Unless cancelled, at least 2 business days (Monday-Thursday) in advance, our policy is to charge for missed appointments at the rate of $25 to the full amount of the scheduled appointment.

_____ _____

Signature of Patient/Guardian Date

Smile dental

Dr. Troy Hutinger
110 W. Sneed St. Centralia, Mo. 65240
573-682-5616 (phone) 573-682-5626 (fax)

CONSENT TO TREAT MINOR PATIENT WITHOUT PARENT PRESENT

In order for us to treat a minor without a parent/legal guardian present, please complete this form:

I, _____ (print name here) am the parent/legal guardian of _____

_____ (print name of minor), currently a minor, whose date of birth is ____/____/____.

I authorize Smile Dental to provide dental care to my son/daughter, including, but not limited to, diagnostic exams, treatment procedures, and prescribing of medications deemed appropriate by his/her provider.

- ☐ **Permission to Apply Fluoride** _____
- ☐ **DO NOT Apply Fluoride** _____

I understand that, should my minor child need more invasive diagnostic or surgical procedures, attempts will be made to contact me before such care is initiated.

I further understand that once my child reaches the age of majority, my consent for treatment is no longer required.

This consent will remain in effect until the patient reaches the age of eighteen unless revoked in writing to Smile Dental Centralia.

Payment is expected the day of the appointment and can be made by cash, check, or credit card when checking in, or in advance over the phone.

By signing this, I acknowledge I have read and agree to this consent and that any questions I had prior to signing this were answered.

_____ _____

Signature of Parent/Guardian Date

Phone Numbers:

Home: _____ Cell: _____ Work: _____

Dr. Troy Hutinger, DDS
110 West Sneed, Centralia, Mo. 65240
Phone (573) 682-5616 / Fax (573) 682-5626

HIPAA Authorization for use or disclosure of health information.

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____ **DOB:** _____

1. My Authorization- I authorize Smile Dental Centralia to use or disclose the following health information:
   - ☐ All my health information
   - ☐ My health information relating to the following treatment or condition:
     _____
   - ☐ My health information covering the period from _____(date) to _____ (date).
   - ☐ Other: _____

   The above party may disclose this health information to the following recipient(s):
   - ☐ Name (title) and organization _____
     Relationship _____ DOB _____
     Phone: _____
   - ☐ Name (title) and organization _____
     Relationship _____ DOB _____
     Phone: _____

   The purpose of this authorization is (check all that apply):
   - ☐ At my request
   - ☐ Other _____

2. My Rights
   - ☐ I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosure have already been made based upon my original permission, I must do so in writing and send it to the appropriate disclosing party.
   - ☐ I understand that uses and disclosures already made based upon my original permission cannot be taken back.
   - ☐ I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standard.
   - ☐ I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.
   - ☐ I will receive a copy of this authorization after I have signed it (if I request it). A copy of this authorization is as valid as the original.

Signature of Patient: _____ **Date:** _____

If patient is a minor complete the following:

Signature of authorized Representative/Guardian: _____

Print Name of Authorized Representative/Guardian: _____

Authority of representative to sign on behalf of the patient listed above:

- ☐ **Parent**
- ☐ **Legal Guardian**
- ☐ **Court Order**
- ☐ **Other** _____